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| **To be completed by the insurance company/applicant:** |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Civil reg. no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Claim no.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**For the physician (to be completed by the company):**

The answers to questions 5a and 5b in the certificate should cover a period of *[10]* years prior to the date of the claim, which is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ddmm-yyyy

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| **To be completed by the examining physician** |
| **1** | a) Are you the patient´s general practitioner?b) If the answer to a) is no:Do you have another treatment-based association with the patient (speciality, place of treatment)?c) If the answer to a and b) is no:I have no treatment-based association with the patient and I have only seen the patient in connection with the completion of this certificate? | **NO YES** 🞎 🞎**NO YES** 🞎 🞎**NO YES** 🞎 🞎 | If **YES**, what kind?………………………………………………………………………………...………………………………………………………………………………… |
| **2** | Diagnosis in Danish and Latin |  | 1. Danish:1. Latin:2. Danish:2. Latin:3. Danish:3. Latin: |
| **3** | In your assessment, could continued or further treatment improve the patient’s condition? | **NO YES** 🞎 🞎 | If **YES**, which treatment or rehabilitation (brief description)?If **NO**, in your assessment, from which date does it seem that there has been no significant progress or improvement in the patient’s condition?……………………………………………………………………………….day/mth/year |
| **4** | Has imaging procedures been performed (such as x-ray examination, ultrasound scan, CT scan, MRI scan)? | **NO YES** 🞎 🞎 | If **YES**, please state:Which type of examination, where and when? (copy of reading should be enclosed if possible)What was the result? |
| **5** | a) To your knowledge, has the patient had any illnesses, complaints or symptoms from the foot and/or lower leg within the last *[10]* years?b) Do you assess, on the existing basis, that illnesses or other conditions within the last *[10]* years have had any influence on the current injury or illness or exacerbated its consequences? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Which?If **YES**, please state:Which? |
| **6** | a) Does the patient state that he/she has resumed work?b) Does the patient state that he/she is able to carry out the daily activities (to be completed **only** for persons who do not work, such as pensioners and children)?c) Does the patient state that he/she is able to oversee his/her business (to be completed **only** for self-employed persons or persons in managerial positions)?d) Which work functions up till now or daily activities does the patient find impossible to carry out? | **NO YES** 🞎 🞎🞎 🞎🞎 🞎 | 🞎 Part-time 🞎 Full-time🞎 Partly 🞎 Fully🞎 Partly 🞎 Fully |
| **7** | **To be completed only if the patient has stated in section 6 that there are activities which cannot be carried out.**What is the medical reason that the patient is not able to carry out these activities? |  |  |
| **8** | What are the patient’s current complaints? |  |  |
| **9** | b) Which side has been injured?b) Which region has been injured? |  | 🞎 Right 🞎 Left🞎 Near the knee 🞎 Mid lower leg 🞎 Near ankle joint |
| **10** | a) Has the position of the lower leg/foot changed (including thickening of bone parts)?b) Are there differences compared to the sound lower leg/foot? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:How?How? |
| **11** | Is there malalignment or shortening at the site of the fracture? (To be completed **only** in case of fracture:)  | **NO YES** 🞎 🞎 | If **YES**, please state:How? |
| **12** | a) Is there normal ankle joint mobility?b) Is there normal rotation of the foot? (pronation and supination of the foot) | **NO YES** 🞎 🞎🞎 🞎 | If **NO**, please complete the following:Right LeftUp (dorsal flexion)(norm 0-20˚) ……………… ………………….Down (plantar flexion)(norm 0-40˚) ……………… ………………….🞎 Slightly reduced 🞎 Slightly reduced 🞎 Moderately reduced 🞎 Moderately reduced🞎 Severely reduced 🞎 Severely reduced |
| **13** | a) Is there laxity of the ankle mortise?b) Is there free mobility of the metacarpophalangeal joint of the big toe? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state: Right Left  🞎 Slightly 🞎Slightly  🞎 Moderately 🞎 Moderately🞎 🞎Severely Severely If **NO**, please complete the following:Upward movement (dorsal flexion)(norm 0-45˚) ………………. ……………….. |
| **14** | Is there muscle atrophy:a) of the thigh (10 cm above the patella)?b) of the calf (largest circumference)? | **NO YES** 🞎 🞎🞎 🞎 | If **YES**, please state:Right LeftCircumference (in cm) ……………….. ……………….Circumference (in cm) ……………….. ………………. |
| **15** | Is there soft tissue swelling of the foot or ankle?a) circumference of lower leg (near ankle)?b) circumference of ankle?c) circumference of midfoot | **NO YES** 🞎 🞎 | If **YES**, please state: Right LeftCircumference (in cm) ……………….. ……………….Circumference (in cm) ……………….. ……………….Circumference (in cm) ……………….. ………………. |
| **16** | a) Is there normal hip joint mobility?b) Is there normal knee joint mobility? | **NO YES** 🞎 🞎🞎 🞎 | If **NO**, please complete the following: Right LeftStretching (ext.)(normal 0/10) ˚) …………… …………..Bending (flex.)(norm 0-130˚) …………… …………..Outward movement (abduction)(norm 0-45˚) .…………… …………….Inward movement (adduction)(norm 0-30˚) ……………. …………….Outward rotation (norm 0-45˚) ……………… ……………. Inward rotation (norm 0-40˚) ………………. ….…………    🞎 Slightly reduced 🞎 Slightly reduced 🞎 Moderately reduced 🞎 Moderately reduced🞎 Severely reduced 🞎 Severely reduced  |
| **17** | Are there oedema, varicose veins, scars? | **NO YES** 🞎 🞎 | If **YES**, please state:Extent and location?  |
| **18** | Are there sensory disturbances? | **NO YES** 🞎 🞎 | If **YES**, please state:Where?  |
| **19** | How is the gait (for example limping, uses a walking stick, two walking sticks, other aids)? |  |   |
| **20** | Any comments? |  |  |
| **21** | Date of examination |  | ……………………………………………………………………………….(day/mth/year) |

Any relevant discharge letters and examination results etc. may be enclosed

The medical information and assessments in this certificate are closely associated with the purpose of the certificate.

Unless otherwise stated, I accept that the company may provide the patient or his/her representative with a copy of the certificate.

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| This certificate has been completed by me in accordance with the existing medical records, my knowledge of the patient, my questions to the patient and my examination of the patient:………………….. ………………………………………………Date Physician’s signature**Exact address (stamp):** | The certificate is sent in a closed envelope marked "Attest" to:  |

Unless otherwise agreed prior to the request to the physician for completion of this certificate, the physician will receive payment upon submission of invoice in accordance with the physician’s terms of business. 04.05.48.04